



Research Award Application

1. APPLICATION TYPE		
<i>Career Development Award</i>	<i>Fellowship</i>	<i>Grant</i>
<input type="checkbox"/> Physician Scientist	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Patient Directed Investigation
<input type="checkbox"/> Medical Dermatology	<input type="checkbox"/> Investigator Research	<input type="checkbox"/> Research Grant
<input type="checkbox"/> Dermatology Surgery	<input type="checkbox"/> Pediatric Dermatology	<input type="checkbox"/> Epiderm. Bullosa
<input type="checkbox"/> Health Care Policy	<input type="checkbox"/> Dermopath Grant	<input type="checkbox"/> Program Development
<input type="checkbox"/> Sci. Human Appearance		
<input type="checkbox"/> Women's Health		
<input type="checkbox"/> Research CDA		
2. TITLE OF PROJECT (Do not exceed 100 characters)		
3a. NAME (Last, First, Middle Initial)	3b. DEGREE (S)	3c. DATE OF BIRTH
3d. CURRENT POSITION TITLE	3e. CURRENT MAILING ADDRESS	
3f. POSITION DURING YEAR OF PROPOSED SUPPORT		
3g. TELEPHONE AND FAX (Area Code, Number and Extension)	3h. E-MAIL ADDRESS	
Tel _____ Fax _____		
3i. U.S. CITIZEN		3j. DERMATOLOGY FOUNDATION MEMBER
<input type="checkbox"/> YES <input type="checkbox"/> NO If no, visa status		<input type="checkbox"/> YES <input type="checkbox"/> NO
3k. AMOUNT REQUESTED	3l. HUMAN SUBJECTS RESEARCH REQUIRING IRB REVIEW/APPROVAL	3m. OTHER FUNDING
\$ _____ for period _____ beginning _____ ending _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> I am \ <input type="checkbox"/> I am NOT . . . currently seeking funds from other sources for this or other projects. <input type="checkbox"/> I am \ <input type="checkbox"/> I am NOT . . . currently receiving support from other sources for this or other projects.
3n. PERCENT OF TIME TO BE SPENT ON RESEARCH TRAINING: _____ % (required ONLY for Fellowships)		
4a. NAME OF SPONSORING INSTITUTION		4b. SPONSORING DIVISION OR DEPARTMENT
4c. DERMATOLOGY DEPARTMENT CHAIR OR DIVISION CHIEF		4d. MENTOR*
Name _____ Title _____ Address _____ Tel _____ E-mail _____		Name _____ Title _____ Address _____ Tel _____ E-mail _____
4e. DERMATOLOGY CHIEF OF SERVICE (If not mentor.)*		4f. FISCAL OFFICER
Name _____ Title _____ Address _____ Tel _____ E-mail _____		Name _____ Title _____ Address _____ Tel _____ E-mail _____
4g. INSTITUTIONAL OFFICER (Dean or designated official.)		5a. DERM. DEPT. CHAIR OR DIV. CHIEF SIGNATURE / DATE
Name _____ Title _____ Address _____ Tel _____ E-mail _____		_____/_____ _____
		5b. INSTITUTIONAL OFFICER SIGNATURE / DATE
		_____/_____ _____
5c. APPLICANT SIGNATURE / DATE "I certify that the statements in this application are true to the best of my knowledge. In the event that I receive simultaneous salary funds from any federal agency or research funds from any other source, as defined in the award eligibility requirements, I understand that my Dermatology Foundation award will be terminated as of the day I begin to receive such funds. I agree to immediately notify the Foundation in writing upon notification of another award. I agree that that salary/research funds awarded to me will only be used for the project/purpose stated in my application. Any unused funds will be returned to the Foundation. I hereby agree to provide a written progress report and financial report to the Foundation within 30 days of the termination of the award."		
_____/_____ _____		

* See instructions. Not required for all awards